STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	12/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/27/11 Facility Number: 000192 Provider Number: 155295 AIM Number: 100291120 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Clinton House Health and Rehab Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (200)	K0000	*This Plan of Correction is the center'scredible allegation of compliance.Preparation and/or execution of this plan ofcorrection does not constitute admission oragreement by the provider of the truth of thefacts alleged or conclusions set forth in thestatement of deficiencies. The plan ofcorrection is prepared and/or executed solelybecause it is required by the provisions offederal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 88 residents and had a census of 73 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/30/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure 2 of 7 locked exit doors unlocked upon entry of a code into the keypad adjacent to the door which was available to the staff at all times. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to be	K0038	It is the policy of this facility that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. All residents have the potential to be affected by the alleged deficient practice. The egress codes will continue to be posted and checked weekly by the maintenance supervisor. All new staff will be orientated during the tour of the facility on the codes to exit and how to contact the maintenance supervisor in case there is a malfunction. All staff will be reeducated on egress route and keeping them open.	01/23/2012

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	carried by staff at all times, or other such reliable means available to the staff at all times. This deficient practice affects staff, visitors, and 29 residents in the 600 hall and 400 hall smoke compartments. Findings include: a. Based on observation with the maintenance director on 12/27/11 between 12:40 p.m. and 3:25 p.m., all exit doors were equipped with a magnetic door lock designed to release upon activation of the fire alarm, a power outage and a code entered into the keypad adjacent to the exit door. The code posted for the 400 hall exit door was entered on 12/27/11 at 12:40 p.m. by the surveyor and the lock failed to open. The maintenance director immediately attempted to open the door using the code and the door could not be opened. He then entered an alternate code which unlocked the door. He said a power surge during the past two days had probably affected the locking mechanism. He said when a surge occurs affecting a lock will		Maintenance Supervisor will ensure that all exit paths are free and clear of obstructions. The Executive Director or designee will monitor for open egress routes both interior and exterior. The egress codes will be monitored by the maintenance supervisor weekly on his rounds. All discrepancies will be reported through the Quality Assurance Committee.	

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	revert back to the manufacturer's original code to open the locks. The door could be opened upon activation of the fire alarm at 3:10 p.m. on 12/27/11. The maintenance director also said the manufacturer's keypad override code was known only to him. b. Based on observation with the maintenance director on 12/27/11 at 2:55 p.m., the code posted adjacent to the 600 hall exit door did not open the magnetic lock holding the door closed. The maintenance director said at the time of observation, this lock was affected by a power surge occurring in the past two days which caused the lock override to revert to the manufacturer's original code. The original code, then entered by the maintenance man, opened the lock. At 2:58 p.m. on 12/27/11, CNA # 1 was working on the hall and was asked to unlock the door. She asked how to do it since she had no idea. She said at the time of interview, she had been employed three months. LPN # 1 was in charge of the unit and was also asked to unlock the door. She entered the code posted for the keypad and			

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	said it didn't work. When asked at the time of observation, she said she was unaware there was an alternate code which might have unlocked the door. The door opened upon activation of the fire alarm on 12/27/11 at 3:10 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 7 exit means of egress was free of all obstructions which could interfere with full instant use. This deficient practice could affect visitors, staff and 13 residents in the 300 hall smoke compartment. Findings include: Based on observation with the maintenance director on 12/27/11 at 2:35 p.m., the 200 hall exit egress was blocked by two straight backed chairs sitting side by side across the exit corridor in front of a medicine cart which was turned to block the exit corridor near the exterior emergency exit. The maintenance director said at the time of observation, the			

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	corridor should not have been blocked. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of 7 means of exit discharge were free from obstruction such as snow which would interfere with its use. LSC 7.1.10 requires that the means of egress be maintained free of obstructions which would prevent its use, such as the accumulation of snow. This deficient practice affects visitors, staff and 36 residents on the 200, 600 and 700 halls. Findings include: Based on observations with the maintenance director on 12/27/11 between 12:30 p.m. and 3:45 p.m., exterior exit discharges from the 400, 600 and 700 halls were each covered with a one inch accumulation of snow. The maintenance director acknowledged at the times of observation the walkways would be slippery and said he had not			

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	had time to get them cleared. 3.1-19(b)			
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation, record review, and interview; the facility failed to provide complete test documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 14 of 14 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants. Findings include: Based on review of TELS, a computer monthly preventive	K0046	It is the policy of this facility that emergency lighting of a least 1 ½ hour duration is provided in accordance with 7.9. All residents have the potential to be affected by the alleged deficient practice. The facility developed and a new form that has a column title "Initial verifying test", in which the person completing the test	01/23/2012

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	maintenance program, for work done with the maintenance director on 12/27/11 at 1:15 p.m., entries to evidence testing of battery operated emergency light fixtures for the past year noted, "emergency lights" and an entry the maintenance director said at the time of review, meant every light was tested and passed. There was no record for the testing of each individual emergency light, its location and a test result. The same was true for the 1 1/2 hour annual test. Lights were checked with the maintenance director on 12/27/11 between 2:20 p.m. and 3:45 p.m. and were all working. 3.1-19(b)		will initial. This Executive Director or designee will sign off on each 30 day document to ensure each emergency light has been tested. All discrepancies will be reported through the Quality Assurance Committee.	
K0048 SS=B	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC	K0048	It is the policy of this facility that a written plans for the protection of all	01/23/2012

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	19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on review of the facility Fire Procedure on 12/27/11 at 1:10 p.m. with the maintenance director and administrator, the plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The administrator acknowledged at the time of record review, the K class fire extinguisher had not been		patients and for their evacuation in the event of emergency. All residents have the potential to be affected by the alleged deficient practice. The facility Fire Policy and Procedure have been adjusted to coincide with the in-service training staff receive and reads "the use of K class fire extinguishers in the kitchen". Staff has been provided copies of the recent wording adjustment made in these policies. The	

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	included as part of the written plan. 3.1-19(b)		Maintenance Supervisor or designee will continue to provide in servicing to staff according to policy on hire and at a minimum of annually thereafter.	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 patios covered by a combustible canopy attached to the building. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice affects visitors, staff and 10 or	K0056	It is the policy of this facility that an automatic sprinkler system is installed in accordance with NFPA 13. All residents have the	01/23/2012

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	more residents who might use the covered patio and adjacent dining room. Findings include: Based on observation with the maintenance director on 12/27/11 at 3:30 p.m., a 16 by 16 foot fabric canopy was attached to the building outside the dining room. The maintenance director said at the time of observation, the canopy was very expensive but he could not provide any documentation to verify the fire resistance of the covering. The area was not protected by sprinklers. 3.1-19(b)		potential to be affected by the alleged deficient practice. The facility obtained a certificate of fire rating from the manufacturer and has it as attachment A on this plan of correction. The maintenance supervisor will obtain certificate of fire ratings for all new constructions and materials. All discrepancies will be reported through the Quality Assurance Committee.	

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 designated smoking areas was provided with a self closing metal container for ashtray waste. This deficient practice affects staff, visitors and 18 residents on the 500 hall. Findings include: Based on observation with the maintenance director on 12/27/11 at 3:05 p.m., a self closing metal container for emptying ashtrays	K0066	It is the policy of this facility that smoking regulations are adopted and include no less than the following provisions: - Metal containers with self closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. All residents have the potential to be affected by the alleged deficient practice. The facility purchased a self closing metal receptacle to attach to the wall of the designated smoking to place all smoking waste products. Staff has been educated on the operation and use of self closing metal receptacle. The maintenance supervisor will	01/23/2012

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	was not provided for the smoking area located outside the 500 hall emergency exit. The only self closing receptacle in the area was made of plastic. The maintenance director acknowledged at the time of observation, the self closing container was missing and said the container was not moved when the location of the smoking area was changed. 3.1-19(b)		monitor for placement on weekly rounds and replace as necessary. All discrepancies will be reported through the Quality Assurance Committee.	
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords and/or unapproved multitap adapters were not used as a substitute for fixed wiring in 2 of 7 smoke compartments. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice	K0147	It is the policy of this facility that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. The rooms identified 518 and 604, were assessed and electrical	01/23/2012

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	could affect staff, visitors and 26 residents in the 500 hall and 600 hall smoke compartments. Findings include: Based on observations with the maintenance director on 12/27/11 between 12:30 p.m. and 3:45 p.m., an extension cord and unapproved multitap outlet adapter were located on the same wall as the resident's bed and used to provide power to equipment in resident room 604. A power strip at the bedside in resident room 518 was used to power appliances in the room. The maintenance director acknowledged the use of the adapters and power strips at the times of observation, and said there weren't enough outlets for all the equipment in these rooms. 3.1-19(b)		devices were reconfigured to meet standards. All residents have the potential to be affected by the alleged deficient practice. Maintenance and housekeeping have done a house wide audit and no flexible cords and cables were found that were used as a substitute for fixed wiring. On weekly rounds the housekeeping supervisor or designee will monitor for flexible cords and cables that were used as a substitute for	

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			fixed wiring and remove from the room and provided to the maintenance director. All current residents and new residents will be provided with the guidelines for use of electrical devices in the facility. All discrepancies will be reported through the Quality Assurance Committee.	